Response to Comments

1915B waiver amendment

May 5, 2005

Greater Hartford Legal Aid, Inc.

March 18, 2005

David Parrella Medical Care Administration -11th Floor Department of Social Services
25 Sigourney Street Hartford, CT 06106-5033

Re: **Proposed Changes to the Connecticut Medicaid Managed Care 1915(b) Waiver (HUSKY A)** published in the Connecticut Law Journal March 1, 2005

Dear Mr. Parrella,

On behalf of over 300,000 HUSKY A recipients and our many clients in the care and custody of the Department of Children and Families ("DCF"), we submit these comments concerning the Waiver Amendment (hereafter "carve-out") proposed by the Department of Social Services ("DSS"). Our detailed comments are below. In summary, although it is not possible to comment comprehensively in the absence of detailed financial information, including the proposed fee schedules referred to at the March 9, 2005 Behavioral Health Oversight Committee meeting and the Value Options response to the RFP, we believe that the proposed carve out may not have all of the desired beneficial effects. This is because of: the absence of adequate funding to ensure appropriate access; complex issues related to coordination of care between the selected ASO and the MCOs, between clients, providers, the ASO and the MCOs, between DSS and DCF; the lack of in depth consumer and provider involvement in the ultimate design of the proposal; and notice of action requirements.

We reserve judgment as to the wisdom of the carve-out; we are not opposed in principle to a carve-out of behavioral health services for HUSKY A recipients. However, based on our many experiences in attempting to secure adequate behavioral health services for our DSS and DCF clients, we have serious concerns about the abilities of DSS and DCF to combine the administration of behavioral health services under one umbrella as a means to ensure that the Community KidCare philosophy becomes something more than just an ideal. We hope you will consider the following comments to the proposal in your ongoing planning of the implementation of the carve-out.

Comments

I. Reimbursement Rates/Fees

Access to needed Medicaid behavioral health services has been a problem of crisis proportions for many years in HUSKY A because of a lack of participating providers and low reimbursement rates/fees. We assume that this crisis is one of the reasons DSS chose to carve-out these services from the rest of Medicaid managed care. Nevertheless, one of the most critical measures of the ability of Medicaid recipients to access services is the reimbursement rates/fees paid to participating providers under the

program. Although there are aspects of the carve-out that may lead to improved access and utilization of behavioral health services, without a significant upward adjustment of reimbursement rates and fees, access and utilization cannot be expected to increase by significant amounts.

A. Carve-out projection (pmpm)

DSS' March 9, 2005 presentation to the Medicaid Managed Care Advisory Council and the HUSKY A Waiver Amendment released March 1, 2005 proposes to remove $19.76 per member per month (pmpm) from upcoming MCO capitation payments and instead use that dollar amount to finance fee-for-service expenditures for the behavioral health carve-out. *Based on earlier figures of behavioral health expenditures under HUSKY A, this amount represents slightly less than the dollar amount that historically has been* attributed to behavioral health services under the MCO capitation payments. Importantly, the $19.76 figure represents both service and administrative costs for behavioral health services. Under the carve-out in year 1 (part of SFY 06), of the $19.76 that will be carved out of the MCO capitation payments, $1.48 pmpm is projected to be attributed to administrative costs, leaving approximately $18.28 pmpm for actual services.[1] [Footnote 1: When Mercer presented its behavioral health services carve-out methodology that resulted in its $19.76 projection and other projections (that will not be addressed here) at the March 9, 2005 Behavioral Health Oversight committee, it acknowledged that for more than one of its analyses, only one or two MCOs complied with requests to supply information for calculation of the projections. It is unfathomable that all of the MCOs did not comply with the requests and somewhat surprising that DSS did not require all of the MCOs to supply the requested information. Such a request should have been made under the threat of sanction by DSS.]

Response: *The $19.76 figure is the pmpm for actual services. This figure does not include administrative costs. The analysis for the waiver amendment assumes an additional $1.48 for administrative costs. Also, this figure does not include the non-Riverview reinsurance cost, which is $3.64. Added together, this results in a grand total of $24.88 of current HUSKY program dollars that would be identified for KidCare. The Governor's budget would add another $9.8 million to provide for growth in service expenditures and any net increase in administrative expenditures.*

With regard to Footnote 1, only one component of the financial analysis was based on MCO data provided pursuant to a November 2003 Request for Information (RFI). This RFI was conducted for the purpose of setting rates under the carve-out and it did not include a request for information on payments for some professional and community services.

All of the MCOs provided all of the requested information, although DSS had to go back to one or more of the MCOs several times in order to get complete or corrected information. One of largest MCOs included an "other" category of expenditures, which was not part of the November request. This MCO then responded to a request for

clarification of the "other" category. When Mercer conducted its analysis for the waiver amendment, it used all available information from the November RFI, including the single MCO's clarification of the "other" data. This MCO's data was extrapolated to the remaining HUSKY population for the purpose of the waiver analysis. Although DSS released another RFI that focused on the "other" category in December 2004, the results were not available in time for the waiver analysis.

DSS did not present a pmpm projection for behavioral health services for year 2 under the waiver. According to DSS, although $19.76 pmpm is the projected amount to be carved out of the MCO capitation payments, the actual amount to be carved out of each MCO's capitation payment is subject to negotiation between DSS and the MCOs, leaving open the possibility that less than the projected amount of $18.28 pmpm for service delivery will be available for actual services under the carve-out. DSS gave no assurances that this amount actually would be available in the carve-out regardless of the result of negotiations with the MCOs.

Response: *The above figures are an actuarial estimate, which may over or under-estimate the true behavioral health service cost. Since the expenditures for behavioral health by each of the MCOs will vary, negotiation with the plans may result in an adjustment of this figure. DSS' intent in the negotiation will be to carve-out the actual identified expenditures with each MCO, in aggregate, the $19.76 plus additional administrative dollars. The Departments believe that these dollars will meet the service needs in line with the goals of KidCare.*

In the event that the dollars appropriated for the carve-out are insufficient to cover the services provided, the Departments will review and analyze the expenditures to determine the factors that caused the expenditures to exceed the projections. If necessary, DSS would seek to increase the available dollars through a Finance Advisory Committee transfer or a deficiency appropriation, as it does for any other entitlement services reimbursed out of the Medicaid account. In addition, any overpayment to the MCOs (where excess behavioral health service dollars were left with the MCOs) will be identified in MCO financial reviews and addressed in subsequent MCO rate adjustments, which typically occur annually

DSS assures that the dollars necessary to cover the true behavioral health service costs under the carve-out will be available regardless of the result of negotiations with the MCOs.

It is also clear from the March 9, 2005 Behavioral Oversight Committee meeting, that the MCOs will retain some amount of pmpm costs for the administration of services associated with the carve-out. There is no justification of this arrangement since the current MCO capitation payments already contain capitated costs for the entire HUSKY A population for pharmacy, non-emergency medical transportation, and other ancillary services that will remain with the MCOs upon implementation of the carve-out. Leaving an additional amount of money with the MCOs for services that they already receive a capitated payment for creates a "double-dipping" problem.

Response: *In the determination of administrative costs that will be carved out of the MCOs, DSS acknowledges that it may be necessary to make some allowances for the MCOs to improve the quality of medical/behavioral coordination beyond current levels and an increase in transportation costs. Any dollars that remain with the MCOs would not be duplicative and thus would not be considered "double-dipping."*

It would be better for DSS to instead direct the pmpm amount of money it plans to leave with the MCOs toward behavioral health services delivery by increasing provider rates or fees by that amount.[2] [Footnote 2: It is also unclear if there are other administrative costs associated with the waiver that might be taken out of the $19.76 projection above. If there are other administrative costs for contractors other than Value-Options for this carve-out, those costs should be disclosed.] As discussed below, there are no provider rate/fee increases in the waiver amendment or in the Governor's budget – as described by Steve Schram of Mercer, no rate actuarial adjustment was made to current rates/fees. That decision was left to DSS. This lack of a rate/fee increase will not increase the number of available providers under the carve-out and may result in the continuation of the behavioral health access crisis under HUSKY A.

Response: *The Departments do intend to provide for behavioral health rate/fee increases as discussed below. With regard to Footnote 2, the $19.76 will not be used to cover administrative costs associated with the administrative service organization (ASO) or any other administrative function.*

B. Provider Rates and Uniform Fees

At the March 9, 2005 meeting discussed above, DSS described the types of reimbursement mechanisms that it plans to use under the carve-out. DSS used the term "provider rates" to describe provider specific (or facility specific) rates, e.g., Hartford Hospital, New Britain General Hospital, psychiatric hospitals and the like would have a specific reimbursement rate. DSS used the term "uniform fees" to describe fee schedules that would be used to reimburse certain other categories of providers, e.g., private psychologists, outpatient clinics, etc. Under any variation of the use of the terms "rates" or "fees", there is no budgeted appropriation or accounting in DSS' cost projections for any upward adjustment of rates or fees under the carve-out.

Response: *The pmpm projections in the waiver financial analysis factor in unit cost increases in behavioral health. Consequently, the $19.76 and the Governor's proposed budget for SFY06 already take into consideration that there will be an increase in BH rates/fees in SFY06.*

Draft fee schedules or provider rates have not been disclosed for comment, although some form of these documents must be available since fee schedules are a critical component in the calculation of overall pmpm projections. [Footnote 3: For this reason, it remains unclear what fee schedules and provider rates were used by DSS and Mercer to

calculate its $19.72 pmpm projection. Without any evidence to the contrary, we assume that the current inadequate fee schedules were used to make cost projections.]

Response: *With regard to the waiver analysis, actual fee schedules and rates typically are not available for waiver analyses of this type. Mercer's analysis includes encounter data at MCO specific fee schedules, which are developed based on submitted encounter data. Encounters for any sub-capitated providers with zero paid amounts are shadow priced using a pricing algorithm based on CT HUSKY MCO fee schedules. Annualized trends of 3-4% were then applied to the base data to derive expected SFY06 costs. In addition, the financial and RFI data included as part of the analysis represent the HUSKY MCOs' actual costs.*

From Mercer's presentation at the March 9, 2005, meeting, it appears that each provider's rates will be the weighted averages of the rates, as of March 1, 2004, paid to that provider by all of the MCOs. The rates would be based on SFY 2003 utilization data.[4] [Footnote 4: Only two of the MCOs submitted data that was used to make the provider rate and uniform fee schedule calculations. DSS needs to place more emphasis on the cooperation of MCOs with DSS or Mercer data requests.] Obviously, this means that provider specific rates will essentially remain static under the carve-out unless there is a future adjustment to the rates. This also means that DSS has some draft provider rate schedules available that should be released to the oversight committee for evaluation and comment.

Response: *Waiver amendments allow for aggregate trends in unit/cost, but typically do not address specific proposals to adjust rates and fees for individual provider types or service categories. The Departments have the flexibility to adjust provider rates and fees under the proposed waiver amendment so long as they do not compromise the state's ability to ensure that overall costs remain with the waiver projection.*

Due to the delay in the implementation of the carve-out since the calculation of provider specific rates, the Departments will allow providers to submit updated rate information for the calculation of provider specific rates.

With regard to Footnote 4, the proposed rate and fee methodology document may have been unclear with regard to data submission. All of the MCOs submitted data in response to the rate and fee related requests for information. As mentioned previously, one MCO submitted additional information related to an "other" category of expenditures, which was also used as part of the analysis. All of the MCOs reported volume, expenditure and rate/fee information for all levels of care as requested. With that said, data completeness and reliability remains a concern. In the future, MMIS claims payment data will provide a much more reliable basis for calculating proposed changes in rates and fees.

To establish the uniform fee schedules for the majority of providers, with the exception of the mental health clinics, it appears that DSS will be establishing weighted average fee schedules based on December 2004 MCO fee schedules. Draft

fee schedules must certainly be available and should be shared with the oversight committee for feedback now. Again, this translates into essentially static fees for a significant number of professionals such as psychiatrists, psychologists, APRNs, home health agencies and school based health centers. Many of these professionals have told us that they are already reluctant to participate in the Medicaid program because of low MCO reimbursements. The failure to make significant future adjustments (including yearly adjustments for inflation) to these fee schedules, will not improve access to these private providers who are a necessary source of care for our clients. By setting uniform fee schedules, it appears that DSS has eliminated the possibility of negotiating with some providers for higher fees in areas where providers are difficult to find. This creates geographic disparities in provider access. This is also unfortunate because unless DSS raises the fees to substantially higher amounts, negotiating power may be necessary to prevent some providers from electing to drop out of the program.

Response: *On March 9th, the Departments proposed weighted average rates as a means to avoid significant changes in billed revenue for participating behavioral health providers. This is a proposed starting point under KidCare. The Departments recognize that future adjustments will be necessary, beginning in SFY06, if the performance of the new system is going to improve. The process for future adjustments is discussed further below.*

The Departments have not eliminated the possibility of geographic rate/fee adjustments or negotiated adjustments. r Improved Access and utilization data will be available under the new system and this data will be used to support additional rate/fee investment strategies of the sort discussed above.

The Departments believe that the current proposed weighted average rates and fees will be sufficient to support continued participation of those facilities and practitioners that are already serving HUSKY members. There were no apparent significant negotiated exceptions for routine outpatient behavioral health services provided by hospital clinics, freestanding clinics and independent practitioners.

With respect to the proposed initial rates, provider specific rates will be shared with each provider. If any provider indicates to the Departments that the calculated weighted average is inaccurate and provides substantiation as such, the Departments will implement procedures to allow for the submission of corrected rate and volume source data and the calculation of corrected weighted average rates. If the correction is implemented after the program implementation, these corrections will be implemented retroactive to the start date of the program.

Similarly, the Departments made weighted average fees available at the Behavioral Health Oversight Committee meeting on April 12, 2005. This has given providers the opportunity to comment on the fees and whether they appear to be reasonable and accurate weighted averages.

The Departments are committed to the correct calculation of base rates and fees and future investments focused on services areas that have a critical need.

For an unexplained reason, DSS has chosen to single out child guidance centers for their own uniform fee schedules that, with the exception of some services, will be set at 55 percent of Medicare rates. According to Mark Schaefer, by setting the fee schedules at 55% of Medicare rates, some individual service rates went up and some went down. Since Mark Schaefer pointed out that rates for some services may go down, and some may go up, it appears at first glance that the uniform fee schedule for clinics may actually be targeted at 55% of Medicare to keep the fee schedule in line with the current MCO fee schedules. Since the current MCO fee schedules are already inadequate, setting fees at 55% of Medicare rates also will be inadequate. DSS should provide further explanation of its rationale for using a percentage of Medicare to set the clinics' fee schedule. Is this an experiment using Medicare fee schedules to set future fee schedules in other service area? Why were mental health clinics chosen for this form of rate setting? Why were the clinics singled out for additional uniform fee schedules for certain other services? Finally, DSS needs to provide to the oversight committee the current Medicare rates and all of the draft clinic fee schedules for review.

Response: *DSS has gradually migrated many providers in Medicaid FFS to fee schedules that pay as a percentage of Medicare (e.g., physicians, psychologists, dialysis centers, independent laboratories, and medical equipment, devices and supplies). This has been done because Medicare has a fairly sophisticated methodology for calculating the relative value of medical goods and services (of which there are more than 10,000) and it is more efficient for the state to adopt these relative values rather than devise its own.*

Although the Departments have proposed to set MH Clinic rates as a percentage of Medicare physician fees, we are willing to use the same simple weighted average methodology for MH Clinics as has been proposed for independent practitioners, including the use of the latest available MH Clinic fee schedules. The Departments provided the current Medicare physician fees and draft clinic fee schedules at the Behavioral Health Oversight Committee meeting on April 12th. The draft clinic fee schedule includes a simple weighted average fee schedule as well as an adjusted fee scheduled in which many of the codes pay at a percentage of Medicare. The Departments also proposed a mechanism to enhance clinic fees beginning in SFY06, as discussed in the response to questions submitted by the Connecticut Community Providers Association.

Although there was some mention at the March 9, 2005 meeting about a proposed adjustment to provider rates once rate adjustments are appropriated for the MCOs, it is unclear how that mechanism will work. Does this mean that DSS will remove an additional portion of the MCO capitation payment from the MCOs and direct it to an adjustment of all of the fee schedules and provider rates once the adjustment to the MCO capitation payments is appropriated? If not, how will DSS pay for increased provider rates and fees? Will only some provider rates and fee schedules be adjusted?

Further, there needs to be a significant rate increase to all providers. Access to timely and quality care are inextricably linked to provider reimbursements, and provider reimbursement must be set at levels that ensure that the levels of access and timeliness of care comply with federal law. 42 U.S.C. § 1396a(a)(30)(a).

Response: *As noted earlier, the pmpm projections in the waiver factor in unit cost increases in behavioral health. Consequently, the $19.76 pmpm carve-out figure and the Governor's proposed budget for SFY06 already take into consideration that there will be an increase in BH rates/fees in SFY06. No additional reduction in the MCO capitation rates will be necessary.*

The Departments are proposing to adjust behavioral health provider rates and fees under the waiver when rate adjustments are appropriated for the HUSKY MCOs. The Governor's budget provides for 2% in SFY06. The 2% applies to the budget for HUSKY MCO capitation rates and the budget for the BH carve-out. The Departments will invest the final appropriated rate increase, which may be more or less than 2%, into behavioral health rates and review any proposed strategic rate methodology with the Behavioral Health Oversight Committee at least 90 days in advance of implementation. The proposed initial investment would be in clinic services for clinics that qualify as enhanced care clinics, as described below in the response to comments submitted by the Connecticut Community Providers Association.

C. Utilization Adjustment

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The 7.76 % utilization increase in behavioral health services that DSS projects in the waiver amendment is a result of the suggested appropriations in Governor's budget. However, there is no evidence in the RFP or in the waiver amendment that supports this estimate. DSS should produce all of the information it relied in supporting its projection of a 7.76% increase in utilization. While we are pleased to see a proposal of additional funding for increased utilization, such an increase in utilization seems highly unlikely without a commensurate significant increase in provider reimbursement rates/ uniform fees. Low reimbursement rates have been a fundamental impediment to achieving the participation of a sufficient number of behavioral health providers. DSS should decide now that if its projected level of utilization increase of 7.76% appears unachievable, which is likely, DSS will use some of the projected funds toward a significant provider rate/fee increase that can be further supplemented at a later time if the increasing provider rates result in increased access and utilization.

Response: *Mercer based its estimate of 7.76% on their experience in other states and the previous study of the Connecticut behavioral service system that they conducted for the Connecticut Behavioral Health Partnership. The utilization increase is included in the waiver as an "upper bound" estimate of what may happen during SFY06, rather than an actual target for the program. The Departments' target under KidCare is to ensure that utilization increases to whatever level is necessary to meet pent up demand. The actual increase in utilization may be more or less than the 7.76% estimate. The Departments will use secret shopper surveys and other methods for assessing network*

adequacy and timely access. If access is timely, pent up demand will decrease and utilization will increase.

Although the Departments believe a number of factors will have a positive impact on utilization, the Departments agree with the above comment that an increase in utilization will depend in part on targeted investment in fee increases for clinic providers. Under the enhanced care clinic proposal, fee increases of 20 to 25% would be tied to new performance requirements such as timely access to routine and urgent outpatient services. The final percentage increase will depend on the amount appropriated for increases in the HUSKY MCO capitation rates and the budget for the BH carve-out.

II. Network Adequacy

Under the waiver amendment it appears that DSS plans to use the current Medicaid fee for service behavioral health network as the provider network for the carve-out. This is significant in that there has been no clear representation that providers in the current Medicaid fee-for-service program will be asked to accept HUSKY A patients.

Response: *Providers in the current Medicaid fee-for-service program will be asked to accept HUSKY A patients. Independent practitioners, general hospital outpatient clinics and freestanding mental health clinics enrolled in the Medicaid FFS program will have an incentive to continue to accept HUSKY A patients because the fees will be higher than under the FFS program.*

Further, it is unclear whether the current recipient to provider ratio for behavioral health services will remain the same under the ASO arrangement and whether certain types of providers will be counted differently toward this ratio from others, as in the case of dental network capacity tracking.

Response: *In aggregate (i.e., across all HUSKY members), the recipient to provider ratio for hospital, freestanding mental health clinic, and home health agency services should remain the same. All HUSKY contracted hospitals, mental health clinics, and home health agencies are enrolled in the Medicaid FFS network. For most members, there will be an increase in the range of choices among hospitals, mental health clinics, and home health agencies because the FFS network includes all such providers and the HUSKY MCO networks tend to include fewer than the full array of such providers. The HUSKY MCOs do contract with a broader array of independent practitioners and the Departments will make every effort to enroll those practitioners that are currently seeing HUSKY members. The Departments have conducted preliminary analyses of network needs with regard to independent practitioner services and expect to begin recruitment efforts in May of this year.*

There is no information presented on the number of providers enrolled in each MCO who are also currently providing services to Medicaid fee-for-service recipients. Such information would be helpful in determining whether using the fee-for-service network might, at least in number, broaden the base of available behavioral health

providers, or constrict. A true broadening of the base of available providers will inevitably require both the expansion of the fee-for-service network and accurate and routine monitoring of provider accessibility.

Response: *As noted above, use of the fee-for-service network will, in number, broaden the base of available behavioral health providers for most levels of care. The fee-for-service network will be expanded to include practitioners that currently only participate in one or more of the HUSKY MCO networks. Other methods will be used to increase outpatient capacity. These include increasing fees for clinics to increase the capacity of these clinics and the recruitment of additional independent practitioners beyond those already enrolled in the HUSKY MCO networks.*

In addition, the ASO is expected to employ 5-8 professionals assigned to individual area offices to promote continuous development of the behavioral health care network in each DCF local area. These ASO staff will work at the systems level rather than with individual children and families. System managers will be required to attend all Managed Service System and Community Collaborative meetings in their assigned local area(s). They will be required to share area specific data and reports to facilitate the work of the Managed Service Systems and Community Collaboratives including identifying service network needs and service system planning. For example, the system managers may identify barriers encountered by local area children and parents including language related service needs, reasons for discharge delays from hospitals, use of Emergency Departments, and delays in accessing specialized services (e.g., trauma, eating disorders) and other needed services.

The System Managers will be responsible for producing a Local Area Development plan. This plan will identify area needs (new behavioral health services, language specialization, clinical specialization, family education and outreach, school engagement, etc.). The plan will also provide specific goals and an action plan to address the identified needs such as recruitment/technical assistance to support enrollment of new providers in critical access areas, education to raise awareness, and outreach to increase participation of schools or non-traditional support agencies.

Under the current managed care system, the MCOs repeatedly claim to have sufficient networks of behavioral health providers. They often cite, as the basis for this, having providers credentialed within their networks, regardless of whether those providers are actually accepting Medicaid patients and providing care. This is an inadequate measure of access to care. The "Geo-access reports" routinely used by the MCOs and DSS to measure provider availability and which are mentioned in the RFP, are also an inadequate measure of actual access to care. Those reports provide extremely limited information as to the location of providers within a network by indicating only whether there is a credentialed provider within a certain radius of eligible recipients. They do not indicate the actual availability of providers to accept new patients. DSS' efforts in the past on ensuring provider availability have not been sufficient. Secret shopper surveys, conducted by an outside entity on a regular, perhaps quarterly, basis are a necessary tool in evaluating provider accessibility. DSS and the ASO must aggressively

monitor the behavioral health provider network by ensuring open provider panels and appointment availability as the true measures of network adequacy.

Response: *The Departments agree. Our efforts to increase capacity need to distinguish real from virtual capacity. The RFP provided for the conduct of "secret shopper" surveys to evaluate network adequacy.*

Finally, it appears that the ASO be responsible for expanding or maintaining the provider network. Is the ASO then responsible for conducting appointment availability analyses in addition, to DSS' own analyses? Will there be sanctions for the ASO if the ASO does not maintain an adequate number of accessible behavioral health providers?

Response: *The ASO will provide assistance in the conduct of network adequacy analyses, the secret shopper survey, and the recruitment of non-traditional service providers through their involvement with Community Collaboratives, DCF area offices and managed service systems. The ASO is expected to employ eight (8) system managers who will be assigned to work with one or more area offices and associated Community Collaboratives to assess local area service gaps and produce a plan for building the base of independent practitioners and non-traditional providers and services (e.g., therapeutic mentoring). The plan will also focus on other areas of development such as improving school involvement with Community Collaboratives and child specific planning teams. The ASO will be held accountable for successfully achieving the goals of its local area development plans. The Departments will be responsible for contracting providers and ensuring adequate funding to support network development and capacity.*

III. Coordination of Care Issues

A. Coordination of Care Between MCOs and ASO

According to the waiver amendment and RFP documents, MCOs continue to be responsible for all behavioral health related laboratory, pharmacy, emergency and non-emergency medical transportation, among other services. While it is admirable that DSS recognizes the need for coordination of services in its waiver amendment, it is inadequate, as a method of assuring recipients that there will not be problems with coordination of care, merely to state that coordination of care requirements will be listed in the contracts between DSS and the MCOs and ASO. Detailed coordination of care requirements should be spelled out not only in the waiver amendment but in other public documents.

Response: *The Departments agree that improved coordination of medical and behavioral health services and other MCO services requires careful planning. Toward that end, the Departments have spent the past year working with the HUSKY MCOs to develop a coordination plan that encompasses the areas noted above. A draft of this plan was distributed at the Behavioral Health Oversight Committee on February 16, 2004.*

We are pleased to see that a coordination of care workgroup has met at least twice

and reviewed a draft coordination of care agreement between the MCOs, the ASO and DSS. Most of the issues raised by that workgroup at its most recent meeting are issues that we also identify below. Complicated issues will undoubtedly arise prior to and during the carve-out's existence that must be addressed in that agreement and by ongoing discussions of coordination of care issues.

DSS states that in the proposed carve-out the ASO will be responsible for assisting in appointment scheduling for EPSDT services. DSS also requires in its current MCO contracts that MCOs assist in appointment scheduling. Further, federal law requires that DSS provide this assistance to the over 200,000 children entitled to EPSDT services. Unfortunately, the MCOs and DSS have interpreted this requirement as merely requiring the provision of a list of ostensible providers within the network to recipients who ask for assistance. As a result of DSS' and the MCOs' failures adequately and regularly to monitor whether providers in the MCO networks are actually accepting new patient appointments, this interpretation can not be considered meaningful, or legally sufficient, assistance.

Response: *The Departments will consider the feasibility of requiring that the ASO offer appointment assistance to all members that request behavioral health referrals. At a minimum, the ASO will invite members to call back if the referrals that the ASO provides are not accepting appointments. In the latter case, the ASO would offer to assist with appointment scheduling when the member calls back.*

Since, under the carve-out, non-emergency medical transportation will remain the responsibility of the MCOs, there is likely to be much confusion and difficulty for consumers, especially consumers with significant behavioral health issues, required to navigate two or three disparate and inefficient management companies. For instance, where a recipient has finally been able to schedule a behavioral health appointment, the recipient might understandably but incorrectly make a transportation request to the ASO, which refers the recipient to the MCO, which then bumps the caller to the transportation vendor. This is likely to result in confusion and delay, if not an outright inability to keep a hard-won appointment.

Response: *The transportation benefit for behavioral health visits will continue to be subject to the same policies and procedures applicable to other HUSKY A covered services. The Departments anticipate that the ease of scheduling transportation will be as good or better than it is under the current system. There are several reasons for this. The four MCOs will have to coordinate with one ASO rather than three behavioral health subcontractors. In addition, the Departments will issue a member services handbook that indicates that transportation services are covered for HUSKY A enrollees and that such services will be covered by the HUSKY MCO with which the member is enrolled. The handbook will indicate that the MCO specific transportation policies apply, that HUSKY MCO recipients should refer to their HUSKY member handbook for details, and arrange for transportation directly with their HUSKY MCO transportation broker. Finally, the ASO's member services unit will be trained to provide information on transportation*

scheduling and will be able to refer the member to the appropriate MCO or transportation vendor or make a warm-line transfer.

As is the case under the current HUSKY program, the ASO will make referrals to the closest appropriate providers (typically 3 names will be given upon request) and avoid referrals to facilities and offices outside of a 25-30 mile radius unless circumstances require otherwise. The ASO will not be required to review provider distance from the member when responding to requests for authorization. The transportation brokers will assess all requests for transportation when contacted by the member and it will be up to the transportation broker and the MCO to apply coverage limitations as appropriate when contacted by the member. In most cases, the transportation broker and/or the MCO will be able to make decisions about whether to authorize transportation to the non-closest provider or to a provider that is outside of the 25-30 mile radius by working directly with the member. However, the ASO will be required to respond to inquiries from the MCO or transportation broker if additional information is needed to support authorization of a transportation request.

Accessing medical transportation has been a serious problem for HUSKY A recipients even without carve-outs. This is due partly to the financial incentive for capitated medical transportation subcontractors under contract with the MCOs to deny trips. Because the entity approving the underlying health services does not pay for or approve the transportation, the approval of those underlying services has not assured transportation to get to them. The carve-out does not offer a solution to this problem, since the ASO approving the behavioral health services will have no control over the capitated entity responsible for providing the transportation, which will continue to have a financial incentive to deny transportation services. We are, therefore, concerned about the accuracy of DSS' statement that the ASO will be responsible for appointment scheduling assistance. Therefore, when a recipient requests medical transportation for a behavioral health appointment, the ASO should be required to directly contact the transportation vendor to arrange for and ensure the transportation.

Response: *The proposed requirement that the ASO would arrange for transportation is beyond the scope of the proposed contract. This would likely add substantial cost to the contract and it may well introduce new problems with transportation scheduling by adding another party to the process. The Departments do intend to assess behavioral health transportation scheduling and reliability in its member satisfaction survey and may then make this a joint quality initiative with the MCOs.*

B. Coordination of Care Between Clients, Providers, ASO and MCOs

1. Client outreach

The first issue to consider concerning coordination of care between clients, the ASO and the MCO is client outreach. Over the years, we have had serious concerns with the adequacy of DSS and MCO communications to recipients on the types and frequency of services to which recipients are entitled under Medicaid, specifically EPSDT services

and recipients' rights to challenge denials of services. The ASO arrangement may add a layer of confusion to the outreach process by adding another entity to the list of entities from which recipients are receiving information.

Response: *Although there is the potential for miscommunication related to Departmental or ASO communication to members regarding behavioral health related services and rights, we believe that the carve-out will provide the opportunity to ensure that comprehensive, uniform, and accurate information is provided to all eligible members. Such information is likely to be more comprehensive and more uniform than is currently the case under the HUSKY program because of the existence of multiple behavioral health subcontractors and corresponding variability in behavioral health coverage, authorization, and reimbursement policies.*

Recipients will need to be informed by DSS well in advance of the implementation of the carve-out in easy to read fashion: a) of the new arrangement for behavioral health administration; b) from what entity they will receive information on a continuing basis concerning behavioral health services; c) the process of selecting a provider, if needed, including a reiteration that recipients have the right to a provider of their choice; d) that certain services are remaining with the MCOs; e) what card they will use for behavioral health services (will it be the ConnectCard or an ASO card). In addition, individually tailored notice to recipients is required to advise them of any new prior authorization requirements that may apply to their individual situations. This type of notice should comply with the requirements stated in Policy Transmittals MS 97-05, 98-29 and 00-08

Response: *The Departments are in agreement with this recommendation. A transition communication plan will be developed by the Departments, the ASO and the MCOs with input from the Behavioral Health Oversight Committee's Transition Planning Workgroup. The members will be able to use the ConnectCard to access behavioral health services.*

Beyond these preliminary outreach issues, there needs to be a comprehensive effort to ensure that children under 21 receive ongoing information concerning their rights: to EPSDT behavioral health screening and treatment services, appointment scheduling assistance, and case management services. There should be sensitivity to the fact that some Medicaid recipients, due to mental health disorders, may have more difficulty than others navigating the new system, and care should be taken to ensure that individuals in this situation are given an appropriate level of assistance by the ASO, DSS and the MCOs. Disabled clients have specific reasonable accommodation rights under the Americans with Disabilities Act, a subject of the current Raymond v. Rowland litigation.

Response: *The Departments agree. Information regarding EPSDT, appointment scheduling assistance, and case management services will be included in the member handbook and in periodic member communications. These topics will also be covered in the training of the ASO member services personnel, whose responsibility it will be to help members navigate the new system. As noted earlier, the management of HUSKY*

behavioral health benefits under a single ASO and the consolidation and standardization of member communications regarding behavioral health benefits and member rights will, in and of itself, make the system easier to navigate than the current system.

2. Language Barriers

Language access issues will undoubtedly present themselves early on if a concerted effort is not made to ensure that outreach and any other materials are appropriately translated. Further, the introduction of the ASO into the process necessitates that extra attention be paid to the possibility of a multitude of language barriers presenting themselves prior to and during the implementation phase of the carve-out. Significant barriers already exist for limited English proficient individuals in accessing services under the managed care structure. These problems could be exacerbated if the proper level of attention is not paid to LEP issues. Thus, DSS and the ASO must make an ongoing effort to ensure that LEP individuals are informed of available services. Interpreter services need to be meaningful available.

Response: *The Departments have addressed issues related to language barriers and interpreter services in the RFP, as it relates to ASO member services. In addition, the ASO will compile language related services in the development of its provider database. This will enable the ASO member services personnel to consider language preferences when making referrals. It will also for the first time allow the Departments to conduct network analyses focused on the availability of access providers that offer access to non-English language therapists and interpreter services.*

3. Client choice of provider

Another issue that arises with the introduction of the ASO structure is that of client choice. Because of the unique nature of using behavioral health services which requires a high level of trust between a provider and a patient, clients must be able to change providers easily and without delay.

Response: *The new system will provide for easy and timely changes in providers without prior approval of the ASO. In some ways, changing providers will be easier under the new system. Members will be able to choose from a broader array of enrolled providers, without MCO specific network limitations. An initial visit will be reimbursable without registration.*

4. Case management services

Case management services are often a critical component in the successful delivery of behavioral health services. Under the current managed care structure, the identification of children who could benefit from case management services is minimal at best, even though case management is an EPSDT required service. Such services are necessary to ensure appropriate care. We have been told on more than one occasion by providers and clients that they have not been told of the availability of case management

services and, therefore, those services have not been provided. DSS' own figures in the waiver amendment from the fourth quarter of 2002 suggest that a maximum of 1067 persons as of that time were referred for case management services under HUSKY A, and only **five** of these referrals were for persons with an ongoing mental health condition. In the second quarter of 2003 only 24 out of the 256 case management referrals were for persons with an ongoing mental health condition. Even assuming all 1067 case management referrals in 2002 were for individual behavioral health conditions, that would represent an overall case management referral rate of only **0.49%** of the HUSKY A child population at the time (using February 2005 enrollment figures for children under 19). Past utilization of these services, therefore, is not an adequate indicator of what the level of future case management services should be. Since many children have not received these services in the past, it is unclear whether, in moving to the ASO model, there have been adequate projections for both the funding of providers of these services and an adequate analysis of the number of children who will or should receive these services.

Response: *Case management will be markedly improved over current levels provided under the HUSKY program. There will be several types of case management as follows:*

- *The ASO will provide intensive care management services. This is a special type of case management service that is targeted toward clients with high or complex needs and clients that are experiencing barriers to effective service. The quality and capacity of these ASO based case management services will be much increased beyond the level that currently exists in the HUSKY program. In addition, these Intensive Care Managers will be assigned to one or more DCF local areas and spend a significant amount of time in the field, working directly with providers and recipients as the need arises.*

- *The ASO will also employ peer specialists who will work in conjunction with intensive care managers to help engage families and adult consumers in treatment.*

- *The fee schedule for clinics (hospital and freestanding) and independent practitioners will provide reimbursement for case management.*

- *The ASO will help link children with complex needs to DCF funded Care Coordination services. Care Coordination is a type of field-based case management, similar to targeted case management, that specializes in wraparound individualized care planning.*

Because of the limited level of appropriations under the ASO model, we remain concerned that individuals who might truly need case management services may not be notified of their availability, or worse, discouraged from getting these services. It is unclear what entity will be responsible for providing these services, if they are necessary – the ASO, the MCO, DSS? If it is the ASO, we are concerned a) that the ASO arrangement will act as a disincentive to providing these services as the ASO will be paid

only an administrative fee for their services and will not receive additional payments for case management services, and b) that there be strict guidelines for care coordination between the ASO, the MCOs and any MCO subcontractors. If it is the MCO or DSS, we have the same concern as to strict guidelines on coordination of care.

Response: *Although there will be annual budget projections for behavioral health services under the carve-out, the budget will be less limited than it is currently as part of the MCOs' capitation rates. As entitlement services paid out of the Medicaid account, payments will necessarily be made to cover the provision of these entitlement services.*

The ASO proposal dedicated substantially more clinical personnel to intensive care management (i.e., case management) than traditional transaction based utilization management. The bidder also proposes to shift utilization management personnel to intensive care management over time as more providers qualify for the bypass program (which eliminates authorization requirements) and the ASO increases its use of outlier management strategies. The final contract will establish staffing levels for intensive care management and it will establish quarterly and/or annual volume requirements. Based on our experience and discussions with other states, specific contract requirements and close oversight will help ensure good case management performance.

The RFP documents suggest that there will be an effort to identify children who are in need of intensive case management, but it is unclear how individuals who could benefit from case management services will be identified since past identification clearly has been inadequate. We would recommend that families be informed now, again prior to the initiation of the ASO model of these services, and once more by the ASO or DSS, of these services upon a first indication by a PCP or other provider of a behavioral health problem. Adequate funding needs to be included in the carve-out for the provision of the proper level of required case management services.

Response: *The Departments will include information about ASO intensive care management, DCF funded care coordination and other case management options in its member handbook and provider education curriculum. The ASO's intensive care management will most often be initiated by the ASO based on criteria that the ASO applies in its review of service requests and analysis of service data to identify members that are at risk. The Department will establish these criteria with the ASO, members, providers, and advocates.*

ICM programs are designed to provide additional clinical supervision and support to recipients with high needs. The criteria for "high need" will be adjusted throughout the contract. High need criteria might include the following:

Children/Adolescents:

- *discharge delay from emergency department, hospital, or residential setting,*
- *multiple emergency department visits in short period of time,*
- *high risk hospital discharge (i.e., multiple risk factors, readmissions),*

- *a serious behavioral health disorder and involvement with police or juvenile justice,*
- *history of unsuccessful connections to care,*
- *failure of foster placement due to behavior,*
- *a co-occurring complex medical condition,*
- *a serious behavioral health disorder and school problems such as suspensions or explusion*
- *transition risk - age 17 years and receiving multiple BH services, and*
- *continuation of any higher level of care (e.g. inpatient, partial hospitalization or intensive outpatient) for more than X days/weeks beyond the average.*
- *more than one family member with requires treatment, especially when more than one provider and agency are involved; and*
- *discharge from inpatient or Riverview to a new out-of-home placement.*

Adult:

- *multiple emergency department visits in short period of time*
- *discharge from a 24-hour level of care after an extended stay;*
- *authorization for 24-hour behavioral health covered services for at least X days in a 12-month period;*
- *length of stay in a 24-hour level of care X days/weeks beyond average for that level of care; or*
- *co occurring complex medical (includes pregnancy) and behavioral health diagnoses that impact a recipient's ability to understand, participate in or comply with treatment.*

In addition, the appropriateness of ICM for an adult could be assessed when:

- *substance abuse is documented during a pregnancy;*
- *the member is homeless and has co-occurring mental illness and substance abuse;*
- *multiple state agencies or providers are involved, necessitating assistance with coordination of care.*

An ICM would typically be involved for a short period of time (1-4 months), but could continue for longer when necessary. The assistance offered by an ICM would vary depending on the barrier or issue at hand. The ICM might convene a case conference, identify and authorize alternative services that had not been considered by the provider or family, resolve communication related issues that interfere with coordination of care, authorize a behavioral health provider to participate in a school planning or IEP meeting, monitor the success of connection to care and intervene if connection is disrupted, facilitate access to and/or enrollment of a provider with special qualifications (e.g., language specialty, eating disorders, applied behavior analysis, trauma, etc.), refer for Care Coordination, or authorize a behavioral consultant to work with a Care Coordinator and Child Specific Team.

In separate sections of the RFP document, there are references to an Individualized Service Plan and Intensive Case Management. No mention of either of these concepts is made in the waiver amendment. It is unclear what, if any, difference there is between these two mechanisms and their relationship to the EPSDT case management requirement. In addition the coordination of care draft agreement does not clearly differentiate between intensive care management and case management. Clarification on this point is necessary. Further, in determining whether "co-management" by an MCO and the ASO, as described in the coordination of care draft agreement, is necessary, deference should be given to the client's medical and behavioral health providers in determining whether a client's primary diagnosis is medical or behavioral.

Response: *Intensive care management is the term that the Departments use for case management activities conducted by ASO staff. Intensive care management involves coordination of care for clients who have higher than usual need and/or are at high risk of poor outcomes. These case management activities are consistent with EPSDT case management requirements, but they are not the only vehicle for the provision of EPSDT case management. As noted, earlier case management may also be provided and billed by clinics and it is provided by DCF funded Care Coordinators and, for DCF involved children, DCF caseworkers.*

The RFP makes reference to individualized service plans. This refers to the service plan developed by a Child Specific Team with the facilitation of a DCF funded Care Coordinator. This type of service planning occurs at the local level in the context of Community Collaboratives or what are sometimes referred to as systems of care.

The Departments appreciate that there is a lack of uniformity and consistency of language and functions, particularly related to activities that can broadly be described as case management, whether conducted by MCOs, behavioral health subcontractors, providers, or care coordinators. This lack of uniformity makes the system that much harder to navigate. The carve-out provides the opportunity to begin to establish consistency and clarity in language and functions. On a related note, the Departments tend not to use the term "case management" to refer to case management activities because consumers and parents tend to prefer other less "case" oriented language.

That the draft coordination of care agreement is sixteen pages long is an indication of how complex coordination of care will be under the carve-out. DSS will need to continually and aggressively monitor the carve-out to ensure that the complexities of care coordination do not result in frustration for clients, providers, the ASO and the MCOs that ultimately leads to a lack of coordination of care.

Response: *The Departments would like to emphasize that the carve-out does not add an additional need for coordination beyond what already exists under the HUSKY program. The carve-out is simpler because the MCOs will have to coordinate with only one ASO, rather than four behavioral health subcontractors. Also, the ASO will be under contract*

with the Departments and the contract will require that the ASO coordinate in kind. We believe that the length of the draft coordination agreement is a strength, rather than a weakness. It demonstrates the efforts that the Departments and the MCOs are making to improve on the coordination of care over and above what currently exists under the HUSKY program.

5. Provider Outreach and Education

While the idea of using one ASO versus several MCO subcontractors to administer the behavioral health benefit at first glance would seem to alleviate some administrative burdens on providers, the number of services remaining with the MCOs that crossover into the delivery of behavioral health services may increase, at least temporarily, the level of administrative burden on providers, clients, the ASO and the MCOs. Behavioral health services are closely related to primary care services, and, according to DSS' utilization statistics, a significant number of behavioral health services are provided by primary care physicians. It is unclear how the ASO arrangement will resolve issues of coordination of care between PCPs and behavioral health service providers.

Response: *Under the HUSKY program, the benefit is already divided within each of the MCOs. Each MCO retains responsibility for primary care behavioral health, transportation, pharmacy, etc. and each MCO carves out responsibility (management and/or contracting and claims) for behavioral health services to a separate behavioral health subcontractor. The division of responsibility is more or less the same under the carve-out, although we believe that we are establishing a more uniform division under a single ASO and correcting some of the crossover problems that currently exist in the HUSKY program. We do not believe that the number of services remaining with the MCOs that crossover into the delivery of behavioral health services will increase.*

For instance, it is unclear how a referral system would work. The following questions all need to be addresses.

Is the PCP allowed to refer a client to a provider of the client's choice?

Response: *Yes, the PCP will be allowed, and indeed encouraged, to refer a client to a provider of the client's choice. Primary care providers will receive education and guidance on how to use the ASO to get their patients connected to the care that they need.*

Depending on the circumstances, the primary care provider has a number of options for facilitating access to a behavioral health provider. In many situations, it may be sufficient for the primary care provider to provide a member with the ASO's customer service number and the member can call directly for referral assistance. In other situations, the primary care provider may wish to provide more direct assistance by contacting the ASO customer service line and obtaining referral information on behalf of the client or by using the ASO's web-based provider search engine.

In still other circumstances, the primary care provider may be concerned that a member has a need for behavioral health services, but that the member either has not connected to care in the past, or is unlikely to follow through on a referral. In this case, the primary care provider can call the customer service line and ask to speak with the ASO's primary care liaison. Together they can problem solve as to what approach would best help a member connect to care. This could include assigning an Intensive Care Manager or a peer engagement specialist to work with the member directly. All of this would necessarily require the member's assent.

Is there to be a system whereby a client has to select a behavioral health provider during an open enrollment or only after a referral?

Response: *A member may select a behavioral health provider whenever the need arises. The member may self-refer, or seek the assistance of the ASO or his or her primary care provider. All HUSKY members will be enrolled with the ASO and receive a member handbook, but only a minority will access behavioral health services in a given year.*

Can a PCP make a psychiatric diagnosis and refer a client for counseling only or will the PCP be required to refer a client to a psychiatrist or psychologist for a diagnosis after a screening reveals a behavioral health issue?

Response: *The PCP will be able to refer a client directly to a licensed behavioral health clinician. A separate evaluation by a psychiatrist or a psychologist will not be required. It is a typical standard of good care that a licensed behavioral health clinician conducts his or her own assessment before commencing treatment.*

If a PCP engages in medication management, we suggest that psychiatric consultation be available to that PCP. Will a PCP have to secure a referral through the ASO or the MCO?

Response: *The Departments agree with the importance of making psychiatric consultation available to primary care providers that are involved in prescribing. We anticipate that the ASO contract will include telephonic primary care psychiatric consultation services. No ASO or MCO authorization will be required.*

If a PCP performs medication monitoring for a client, does a PCP bill off of a DSS fee schedule for that service or does he bill from a MCO fee schedule?

Response: *Medication monitoring will be covered under the primary care provider's contract with the MCO at whatever fee is specified in the contract. The MCOs understand that they will be financially responsible for these services and they will ensure that their claims systems process primary care claims with a primary behavioral health diagnosis.*

Will there be a DSS fee schedule and an MCO fee schedule for overlapping services?

Response: *We do not anticipate that there will be overlapping services.*

There must be significant outreach to providers on the transition to the ASO arrangement, any new prior authorization requirements for their individual patients, the requirements for proper delivery of EPSDT services including case management services, and available assistance for clients who have language barriers. Providers should be informed well in advance of any new forms that will be used by the ASO. Providers should vet the adequacy of claims forms, prior authorization forms and the like, prior to the carve-out implementation to ensure that the carve-out does not increase administrative burdens on providers that could lead to providers leaving the Medicaid program. Just as DSS needs to assure that recipients will have no barriers in continuity and coordination of care, it needs to do the same for providers.

Response: *The Departments will take steps to ensure outreach to providers related to the transition to the ASO arrangement, any new prior authorization requirements for their individual patients, the requirements for proper delivery of EPSDT services including case management services, and available assistance for clients who have language barriers.*

Providers will be informed well in advance of any new forms that will be used by the ASO. The Departments will offer the Behavioral Health Oversight Committee the opportunity to review any new forms prior to the carve-out implementation to ensure that the carve-out does not increase administrative burdens on providers that could lead to providers leaving the Medicaid program. The Departments have a strong interest in reducing unnecessary administrative burdens. Administrative burdens associated with the new system will be monitored as part of the annual provider satisfaction surveys.

6. Monitoring of Coordination and Continuity of Care

DSS represents in the waiver amendment that continuity of care and coordination of care will be monitored by appeal and grievance process, calls to HUSKY InfoLine and through case reviews. However, past experience with prescription drug and dental care access issues shows that the number of filed grievances, appeals and calls to the HUSKY InfoLine reveal only a very small fraction of the true number of clients with access to care and coordination of care issues. DSS must do more to ensure coordination and continuity of care than to undertake only the limited monitoring measures above.

Response: *Continuity of care and coordination of care may also be monitored through member surveys and connection to care analyses that are outlined in Exhibit E of the RFP. The Departments are interested in exploring other methods for measuring this aspect of the system's performance. Legal services staff and other interested persons are invited to participate on the Behavioral Health Oversight Committee's Quality and Access workgroup which will be focusing on the measurement of the system's performance.*

C. Coordination of DCF and DSS re behavioral services for DCF clients

There is an **"**elephant in the room" concerning the delivery of behavioral health services under this carve-out, and that elephant is the multitude of DCF clients who are HUSKY A recipients and who are placed in residential care because of the failure to find community based placements in which comprehensive behavioral health services can be provided. The carve-out does not address this serious problem and there is no indication that simply changing the administration of the services via the carve-out will lead to improved outcomes for recipients in DCF custody. Unwillingness to address this issue is one of our major concerns. Two of the concrete goals of the carve-out should be to reduce the number of children in DCF custody by moving toward community based placements, and to lessen the number of individuals coming into DCF care by providing comprehensive community-based behavioral health services. Too often we have seen the consequences of children forced to remain in institutionalized settings for years because of the lack of planning or effort to allow these children to live in community settings where they can transition into adulthood in a safe setting. We have seen little evidence over the years of efforts to address this issue. The carve-out should address this issue as DSS and DCF share the burden of ensuring that children in DCF custody receive the services they need.

Response: *The carve-out will provide new opportunities for enhancing access to community-based services for DCF involved children as well as children at-risk of DCF involvement. Some of these opportunities are outlined below:*

- *The Departments will introduce therapeutic mentoring on a fee-for-service basis, which is currently grant funded and available on a limited basis. Therapeutic mentoring is one of the most often sited deficiencies in wraparound individualized service plans. Conversion to fee-for-service will make it possible to increase service capacity to meet demand.*

- *The Departments will also introduce behavioral consultation on a fee-for-service basis. A network of expert community-based behavioral health clinicians will be available to consult to child specific teams and support wraparound care planning for some of our most challenging children.*

- *The Departments will also increase the availability of fee-for-service home-based services so that these services can increase capacity to meet demand. Improving flexible capacity in these and other services will help provide timelier access and help avoid unfavorable outcomes.*

- *The Departments propose to invest in fee increases in SFY06 for clinics that meet new requirements (i.e., enhanced care clinics), including timely access to psychiatric evaluation and medication management services. Access to psychiatric services is one of the issues that can delay discharge from residential treatment.*

- *The Departments will introduce new performance measures that allow the ASO and the Departments to assess the system's performance with regard to special populations including, for example, children involved in DCF juvenile justice, child protection and voluntary services and children in transition to the adult system. The ability to measure timely access to services and connection to care after a residential stay for these special populations is essential if we hope to resolve the special access and coordination issues that affect them.*

- *As noted in Exhibit E of the RFP, the ASO will monitor discharge delays from residential and hospital settings and the reason for those delays, by subgroup, so that the Departments can focus on addressing the root causes of such delays.*

- *The ASO's intensive care management program will help identify children and their caregivers with complex needs and children at risk of poor outcomes and help connect them to appropriate care. The Departments believe that this new ASO service, coupled with expanded capacity in community services, will help avert unnecessary involvement in the DCF child protection, juvenile justice, and voluntary service systems and otherwise reduce poor outcomes.*

For instance, what planning will take place between residential settings and community providers to ensure appropriate services for DCF kids? Residential treatment centers ("RTCs") often have their own behavioral health staff on site. We have found that while this may be helpful, RTC clients have little choice as to whom their provider is, and when specialty care such as trauma treatment is needed, the RTCs can do little to provide that treatment. There is nothing in the waiver amendment or in the RFP addressing this coordination of care problem and ensuring DCF client access to the provider of his or her choice and a provider who can provide appropriate treatment until a transition can be made to the community. The historical unwillingness of DCF to go outside its own facilities to provide an appropriate level of care makes us doubtful that this issue will be resolved by moving to an ASO model. There is nothing in the language of the RFP or the waiver amendment that appears to make an attempt at resolving this issue, but the issue needs to be resolved, with or without the carve-out. We strongly believe that there must be a clearer delineation of the roles of DSS and DCF in ensuring that EPSDT behavioral health services requirements are met for children in DCF custody.

Response: *The efforts made by the ASO to monitor and plan for appropriate care and discharge options for children in residential treatment will be enhanced by DCF's Managed Service Systems (MSS); area office collaboratives that include DCF staff, local service providers, and care coordination agencies. Each MSS meets weekly to review the status of DCF involved children referred for out-of-home care who have high or complex needs and who require specialized care plans. The purpose of the MSS is to solicit the clinical expertise of local DCF funded providers in treatment and permanency planning efforts for the identified children and, when appropriate, to develop creative clinical alternatives to residential care.*

In addition, DCF has written new contract language for residential providers that requires them to identify specific target populations of children to be served within their program and to identify evidenced-based or best practice treatment models to address the clinical needs of the children to be served. Child specific treatment goals and objectives for children entering residential treatment will be informed by the comprehensive global assessment process, a recently developed clinical evaluation designed by DCF. The assessments will be implemented by licensed mental health practitioners who will be trained and credentialed by DCF to conduct a thorough clinical and psycho-social evaluation for the specific purpose of planning care for children referred for residential treatment. Pre-admission planning conferences, informed by the results of the comprehensive global assessment will be held with the identified residential provider, DCF staff, and when appropriate, the child and caregiver. The ASO care management process will subsequently monitor treatment progress and facilitate discharge planning to clinically appropriate community based treatment services. Whenever possible and appropriate, discharge planning will involve providers known to the child and family to support continuity of care. At the very least, discharge planning will include the providers responsible for follow-up care.

These efforts are designed to enhance the clinical process for children entering residential care, and to ensure that treatment within the chosen setting is therapeutically matched to the child's needs and is coordinated back to the child's home community.

IV. Lack of Broad-Based Consumer/Provider Involvement

While we applaud the efforts of DSS to be more open about its plans concerning the behavioral health carve-out than it was with its earlier plans on the dental carve-out, there remains a significant level of undisclosed information on the details of the carve-out that have led to a less than desirable amount of consumer and provider involvement in the design of an appropriate plan. For instance, lack of detail on proposed fee schedules makes it nearly impossible for providers to give proper feedback on their ability to provide adequate services to recipients. While the workgroups established by the Behavioral Health Oversight Committee are a positive addition to the development of the carve-out, a broader dissemination of workgroup and oversight committee meeting agenda and draft documents such as the coordination of care draft agreement would be useful so that interested parties who are not available to attend meetings and who are not members of the workgroups are able to have input into the carve-out. Further, the presentation of more detailed information in public places, including the DSS website, may increase the confidence of recipients, and the public, in the program or lead to a reconsideration of some issues by DSS before implementing the carve-out.

Response: *The Departments agree with the commenter that public input, and particularly provider and parent input are essential to this reform. Since its inception in 1998, KidCare has been designed as a collaborative effort between the Department of Children and Families, the Department of Social Services, providers and consumers. Recognizing that the philosophical and clinical premises within KidCare are built upon partnerships between consumers, providers and state agencies, both DCF and DSS have made*

provider and parent input paramount in the planning process. In addition, the Departments have released several legislative reports that detail the program design.

The following list summarizes legislative reports and forums that have included providers in the development and design of KidCare and the Administrative Services Organization model. In all of these forums, the basic principles of the model have been supported, a carve-out of behavioral health from the HUSKY MCOs, the creation of a single administrative infrastructure, including an ASO under joint contract to the Departments and with no financial incentive to deny care. Although rates and fees have been an issue, the current rate and fee proposals address those issues by providing for provider specific blended rates, increased rates for clinic providers, and the opportunity for future rate investments.

- *Delivering and Financing Children's Behavioral Health Service in Connecticut A report to the Connecticut General Assembly Pursuant to PA 99-279 from the Department of Social Services, February, 2000*

  This initial report prepared by the Child Health and Development Institute under agreement with DSS, served as the first document within the reform to identify problems within the children's behavioral health system (i.e, access to care, coordination of care, quality of care) and the total state dollars spent on children's behavioral health. The report advocated the need for a system of care model that was community based and managed through an Administrative Services Organization. An advisory committee oversaw this study and included state agency personnel from DSS, DCF DMR, OPM, DMHAS, and SDE, family and consumer representatives, and providers including Dr. Steve Larcen from Natchaug Hospital, Ms. Sherry Perslstein from the Child Guidance Center of Southern CT and Ms Tracey Halstead from the CT Association of Nonprofits.

- *Connecticut Community KidCare: A Plan to Reform the Delivery and Financing of Children's Behavioral Health Services: A Report to the CT General Assembly Pursuant to PA 00-2, Section 5 from the Department of Children and Families and the Department of Social Services, January 2001*

  This report served as a follow-up to the 2000 report and provided detail about reforming the children's behavioral health system. It introduced the concept of a full carve-out of behavioral health services from the HUSKY MCOs and an ASO under direct contract with DSS and DCF. In addition to the continued input from the team members who are listed above, a Request for Information related to the proposed reform was issued in August 2000. Written comments from 44 sources were obtained: 17 were from specific Connecticut providers and three were from trade organizations. In addition, two, three hour public hearings were held to solicit feedback from consumers and providers. The information from these hearings was also incorporated into the report and into additional planning activities.

- *Connecticut Behavioral Health Partnership: Developing an Integrated System for Financing and Delivering Public Behavioral Health Services for Children and Adults in Connecticut: A Report to the CT General Assembly Pursuant to PA 01-2, JSS Section 49 and Public Act 01-08 JSS.*

  This report proposed an expansion of the Kidcare model to include adult Medicaid fee-for-service beneficiaries and the General Assistance Behavioral Health Program.

- *KidCare Workgroups: Between September 2001 and April 2003 five different KidCare workgroups were convened to address various programmatic and system design issues. All were staffed by representatives from DCF and DSS, parents of children who used behavioral health services, members of children's advocacy organizations, and the following providers.*

  Eligibility Workgroup: Dr. L. Philip Guzman, Child Guidance Clinic of Greater Bridegport.

  Service System Design: Chet Brodnicki, Clifford Beers Child Guidance Clinic; Sherry Perlstein, Child Guidance of Southern CT; Doug DeCerbo, Boys and Girls Village

  Clinical Management/Levels of Care: Heather Gates, Community Heath Resources; Mike Russo/Susan Walcama, Wheeler Clinic; Jean Adnopoz, Yale Child Strudy Center; Donna Mercadante, Gray Lodge

  Rehabilitation Option: Heather Gates, Community Health Resources; Steven Girelli, Klingberg Family Centers; Susan Walkama, Wheeler Clinic

  Residential and Group Home Clinical Criteria/Level of Care: Liz Bryden, The Village for Children and Families; James Clark, Noank Baptist Group Homes; Doug DeCerbo, Boy's and Girl's Village; Anthony DelMastro, The Children's Center of Hamden; David Jacobsen, Children's Home of Cromwell; Anna Kemper, Waterford Country School; Donna Mercandante, Gray Lodge; Michael Russo, Wheeler Clinic; Tammy Sneed, NAFI Connecticut; David Tompkins, Rushford Center

- *Connecticut Community KidCare Child Implementation Team: Established in 2001 and responsible for KidCare planning and implementation, this team has included parent representation for most of its tenure.*

- *Children's Behavioral Health Advisory Committee: The Children's Behavioral Health Advisory Committee is a statutorily established committee charged with advising the Department of Children and Families on the child behavioral health system. This committee is comprised of at least 51% parents of children with*

serious behavioral health disorders, in addition to state agencies and providers. The Departments have met with this group since it was established in xxx and have sought input into the design and development of KidCare related reforms including the ASO and HUSKY BH carve-out. The Departments sought guidance on KidCare ASO policy related matters including utilization management policies and the fee increases provided for under the enhanced care clinic proposal. Many of the ideas of this committee have been incorporated into the plan.

- *Behavioral Health Subcommittee of the Medicaid Managed Care Council: The Departments have attended monthly/bi-monthly meetings of the behavioral health subcommittee, which includes representation from the HUSKY MCOs and providers. The Departments have discussed the design of the reform and provided the opportunity for advice and guidance for more than four years.*

- *Medicaid Managed Care Council: The Departments have presented the model to and solicited input from the Medicaid Managed Care Council.*

- *BHP Legislative presentations, 2004 legislative session: The Departments made six presentations to legislators and the public related to the Behavioral Health Partnership, which included the KidCare reform. The Departments incorporated feedback in that reform as well including related to utilization management and rate setting policies. The presentations were widely attended by general and psychiatric hospitals, community clinic providers, and home health.*

- *Requests for Proposals: Parents and child advocates provided input into the development of the Behavioral Health Partnership RFP (released October 2002) and the evaluation of the Partnership RFP responses and they were also involved in the development of the Connecticut Community KidCare RFP (released October 2004) and the evaluation of KidCare RFP responses.*

- *Other: The information obtained through the above forums, in addition to numerous meetings with the Connecticut Association of Non-Profits, The CT Council of Provider Agencies, and FAVOR, a network of family advocacy organizations, have helped to inform the design of the reform and the RFP that was released in September 2004 for the Administrative Services Organization. This information has also guided DCF's decisions around which community-based services were needed to ensure KidCare's success and prompted the RFP processes for emergency mobile psychiatric services, care coordination, intensive home-based services and crisis stabilization units*

The Departments have also published quarterly KidCare reports. These materials and the above noted reports have been available on the DCF website and were formerly available on the Behavioral Health Partnership website. The Departments are in the process of developing the Connecticut Community KidCare website (www.connecticutcommunitykidcare.state.ct.us). We are preparing to post past and future reform related materials on this site.

Members of the public that wish to receive materials disseminated at the Behavioral Health Oversight Committee meetings or those of its workgroups should contact Mariette McCourt at (860) 240-0321 or mariette.mccourt@cga.ct.gov. In addition, meeting materials and summaries are available on the Medicaid Managed Care Council website at www.cga.ct.gov/ph/medicaid.

V. Notices/Grievances/Fair Hearings

Finally, with respect to notices of action, while the RFP lists the requirements of notice with respect to the grievance and fair hearing processes, the ASO's grievance process and its notice templates are not included in the waiver amendment or in any other public document. We recommend that the draft notices and an outline of the ASO grievance process be disclosed to the oversight committee for review and comment prior to their use, especially given the flaws in notices issued by the MCOs that have given rise to litigation.

Response: *The Departments will offer the Behavioral Health Oversight Committee the opportunity to review and comment on draft notices and an outline of the ASO grievance process prior to their implementation.*

Further, the coordination of care draft agreement states that the KidCare ASO will not issue notices to the HUSKY MCO and vice-versa. However, the agreement goes on to state that, "[i]f a HUSKY MCO or one of its providers disagrees with a clinical management decision made by the KidCare ASO, the HUSKY MCO is encouraged to raise the issue with the ASO on behalf of the client and the resolve the issue informally prior to the scheduled fair hearing. The converse is also true." (*See* draft agreement, Coverage and Coordination of Medical and Behavioral Services, February 2005, page 12.) In order for the type of resolution described to take place, DSS must require that notices be issued by the KidCare ASO to the MCO and vice-versa. Otherwise, it is extremely unlikely that such an informal resolution could ever be reached prior to a hearing.

Response: *Based on discussions with the MCOs, the Departments were under the impression that these reciprocal notices are not currently acted on and a decision was made to discontinue their use to reduce administrative burden. The Departments will revisit this issue with the Behavioral Health Oversight Committee's Coordination of Care workgroup in light of these comments.*

Thank you for your attention to these comments.

Sincerely,

Victoria Veltri Staff Attorney
vveltri@ghla.org

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Sheldon V. Toubman New Haven Legal Assistance Assoc. Inc. 426 State Street New Haven, CT 06510-2018 (203) 946-4811 (203) 498-9271—fax

cc: Governor M. Jodi Rell Patricia Wilson-Coker, DSS Commissioner Darlene Dunbar, DCF Commissioner Connecticut General Assembly Committee co-chairs:

Appropriations: Sen. Toni Harp, Rep. Denise Merrill Public Health: Sen. Christopher Murphy, Rep. Peggy Sayers Human Services: Sen. Mary Ann Handley, Rep. Peter Villano

Jeanne Milstein, Child Advocate

Richard Blumenthal, Attorney General

Center for Medicare and Medicaid Services

Connecticut Community Provider's Association

March 18, 2005

David Parrella, Director, Medical Care Administration
Medical Care Administration – 11th Floor
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

Re: Notice of Proposed Changes to the Connecticut Medicaid Managed Care 1915 (b) Waiver (HUSKY A)

Dear Mr. Parrella:

Please accept these comments with regard to the posting in the March 1, 2005 Connecticut Law Journal about the Notice of Proposed Changes to the Connecticut Medicaid Managed Care 1915 (b) Waiver (HUSKY A).

The Connecticut Community Providers Association (CCPA) represents organizations that provide services and supports for people with disabilities and special needs including children and adults with addictions, mental illness, developmental, and physical disabilities.

Our members provide grant-based and fee-for-service mental health and addiction treatment services for DMHAS, DCF and DSS. The proposed amendment to the HUSKY A program will have a significant impact on the services we provide. While most of the effect will be on children's mental health services, a significant number of adults will be covered under this proposed waiver amendment for behavioral health services and will have an impact on clinic, partial hospital and other levels of care for adults.

We have indicated our support for this carveout of behavioral health services under the HUSKY program in public testimony and many legislative venues and continue to voice that support, assuming certain protections are assured as basic provisions of the waiver.

We support a HUSKY carveout that:

- Assures a rate structure reflective of the cost of providing services
- Creates a process for public input
- Provides for legislative oversight

- Reinvests federal dollars into the behavioral health system

The comments below amplify these points.

Rate Structure

Of critical issue to our members is a delivery structure that enhances access to services. Most of the child guidance clinics that we represent, for example, currently have waiting lists for services. The combination of grant funding, HUSKY MCO funding and FFS private pay is insufficient to allow the clinics to serve everyone who seeks their services. We anticipate that the HUSKY carveout will provide for increased access to an increasingly needy population.

We support the concept that we have discussed at length with DSS of "enhanced care clinics" that will provide a more comprehensive array of services, providing greater access to services. Such "enhanced care clinics" for child and adult services will rely heavily on an increased rate structure to pay for these enhancements.

We have serious concern that the funding proposed in the Governor's FY06/FY07 budget will be insufficient to assure an increase in access for consumers and a higher payment rate for service providers. As of yet there have been only preliminary discussions about the proposed rates. Our support of the final waiver plan depends on the sufficiency of the proposed rate structure.

Response: *The pmpm projections in the waiver analysis factor in unit/cost increases in behavioral health. Consequently, the $19.76 pmpm carve-out figure and the Governor's proposed budget for SFY06 already take into consideration that there will be an increase in BH rates/fees in SFY06. No additional reduction in the MCO capitation rates will be necessary.*

The Departments are proposing to adjust behavioral health provider rates and fees under the waiver when rate adjustments are appropriated for the HUSKY MCOs. The Governor's budget provides for 2% in SFY06. The 2% applies to the budget for HUSKY MCO capitation rates and the budget for the BH carve-out. The Departments will invest the final appropriated rate increase, which may be more or less than 2%, into behavioral health rates and review any proposed strategic rate methodology with the Behavioral Health Oversight Committee at least 90 days in advance of implementation.

The Departments will propose to implement the enhanced care clinic concept for freestanding mental health clinics effective October 1, 2005. The requirements would be determined in consultation with the Behavioral Health Oversight Committee. The Governor's proposed 2% increase for the HUSKY program would be sufficient to enhance rates by 20 to 25% for qualifying clinics in SFY06. The Departments would propose to use any appropriation in excess of 2% to implement the enhanced care clinic concept for hospital outpatient clinics. It is anticipated that the vast majority of clinics will eventually qualify for this enhanced reimbursement.

Public Input

We have been pleased with the opportunity to date for public participation in the process of closing out the current waiver and implementing the new waiver. The Behavioral Health Oversight Committee of the Medicaid Managed Care Council and its subcommittees provide a very useful vehicle for input from the private provider members into the implementation process. We also appreciate the willingness of DSS and DCF staff to discuss waiver provisions with us at Association meetings.

We have raised a number of "transition" issues with the Behavioral Health Oversight Committee for which we are waiting resolution, including: reconciliation of claims from the current MCOs and payment guarantees, an audit of FY03 and FY04 receivables/payables and the potential for contractual withholds from the current MCOs until all claims have been settled and paid.

We have encouraged the Behavioral Health Oversight Committee to create a rate subcommittee as well as its other subcommittees so that the proposed rate structures have sufficient vetting.

Response: *DSS has introduced new provisions in the HUSKY contract that offer protections related to subcontractors and contract terminations (see below section 3.45 Subcontracting for Services, subsections a, e, g, h, j and k). The new provisions resulted in part from difficulties associated with the termination of ProBehavioral Health as the behavioral health subcontractor for HealthNet. DSS intends to enforce these provisions in relation to the termination of behavioral health services under the HUSKY MCOs and the implementation of the carve-out. This process will begin at least 120 days in advance of the carve-out date. A summary of the MCO termination and transition plans and the status of the implementation of those plans will be shared with the Behavioral Health Oversight Committee's, Transition Workgroup.*

3.45 Subcontracting for Services

a. Licensed health care facilities, group practices and licensed health care professionals operating within the scope of their practice may contract with the MCO directly or indirectly through a subcontractor who directly contracts with the MCO. The MCO shall be held directly accountable and liable for all of the contractual provisions under this contract regardless of whether the MCO chooses to subcontract their responsibilities to a third party. No subcontract shall operate to terminate the legal responsibility of the MCO to assure that all activities carried out by the subcontractor conform to the provisions of the contract. Subcontracts shall not terminate the legal liability of the MCO under this contract.

e. All behavioral health and dental subcontracts which include the payment of claims on behalf of HUSKY A Members for the provision of goods and services to HUSKY A Members shall require a performance bond, letter of credit, statement of financial reserves or payment withhold requirements. The performance bond, letter of credit, statement of financial reserves or payment withhold requirements shall be in a

form mutually agreed upon by the MCO and the subcontractor. The amount of the performance bond shall be sufficient to ensure the completion of the subcontractor's claims processing and provider payment obligations under the subcontract in the event the contract between the MCO and the subcontractor is terminated. The MCO shall submit reports to the DEPARTMENT upon the DEPARTMENT's request related to any payments made from the performance bonds or any payment withholds.

g. All subcontracts shall include provisions for a well-organized transition in the event of termination of the subcontract for any reason. Such provisions shall ensure that an adequate provider network will be maintained at all times during any such transition period and that continuity of care is maintained for all Members.

h. Prior to the approval by the DEPARTMENT of any subcontract with a behavioral health or dental subcontractor, the MCO shall submit a plan to the DEPARTMENT for the resolution of any outstanding claims submitted by providers to the MCO's previous behavioral health or dental subcontractor. Such plan shall meet the requirements described in subsection (j) below.

j. In the event that a subcontract is terminated, the MCO shall submit a written transition plan to the DEPARTMENT sixty (60) days in advance of the scheduled termination. The transition plan shall include provisions concerning financial responsibility for the final settlement of provider claims and data reporting, which at a minimum must include a claims aging report prepared in accordance with Section 3.39 (c)(5) of this contract, with steps to ensure the resolution of the outstanding amounts. This plan shall be submitted prior to the DEPARTMENT's approval of the replacement subcontractor.

k. All subcontracts shall also include a provision that the MCO will withhold a portion of the final payment to the subcontractor, as a surety bond to ensure compliance under the terminated subcontract.

The Departments believe that these requirements will be sufficient to ensure that the MCOs and their subcontractors meet their outstanding behavioral health related financial obligations. In addition, ValueOptions has committed to resolving all issues raised by Connecticut providers with regard to its HealthNet account. Specifically, it proposes to augment the current claims resolution process by adding a single point of contact in Connecticut to coordinate communication between providers and the ValueOptions Connecticut Providers Committee, continue to schedule meetings with providers at their offices or at the ValueOptions Connecticut Service Center to review findings of claims audits, and negotiate a performance standard related to the resolution of claims payment issues from prior contract periods as part of the KidCare contract.

Legislative Oversight

The Behavioral Health Oversight Committee is co-chaired by Senator Chris Murphy, co-chair of the Public Health Committee and includes strong participation by other

legislators. We trust that this legislative involvement will carry forward in FY06/FY07 budget development and legislative recommendations governing the HUSKY carveout.

Response: *The Departments support the continuation of the Behavioral Health Oversight Committee and legislative involvement in the oversight of the HUSKY carve-out.*

Reinvestment of Funds

While we recognize the cost neutrality of the proposed waiver amendment, it is essential that any funds garnered through savings in payments to MCOs under the current plan be reallocated into the proposed HUSKY carveout to improve access and cover enhanced rates.

Response: *Any funds garnered through savings in payments to MCOs under the current plan will be reallocated into the proposed HUSKY carve-out to improve access, cover enhanced rates, and support essential coverage enhancements such as therapeutic mentoring.*

Thank you for the opportunity of commenting on the proposed waiver amendment.

Sincerely,

Terry Edelstein
President/CEO

cc: Patricia Wilson-Coker, Commissioner
CCPA Members
Senator Christopher Murphy, Co-Chair, Behavioral Health Oversight Committee
Jeffrey Walter, Co-Chair, Behavioral Health Oversight Committee

Greater Hartford Legal Aid, Inc.

April 4, 2005

David Parrella Medical Care Administration -11th Floor Department of Social Services
25 Sigourney Street Hartford, CT 06106-5033

Re: **Proposed Changes to the Connecticut Medicaid Managed Care 1915(b) Waiver (HUSKY A)** published in the Connecticut Law Journal March 1, 2005

Dear Mr. Parrella,

We hope that you will accept this addendum to our comments on the proposed waiver amendment. In order to more thoroughly inform the agencies and vendors involved in the proposed carve-out, and in order to enhance consumer participation in the process, we recommend that DSS and DCF hold public hearings in several locations around the state during evening or weekend hours. These hearings would give affected families an opportunity to relate their own experiences with the current HUSKY system, suggest effective solutions to potential coordination of care problems, and to fully participate in the dialog around this program change. It will also allow DSS and DCF the opportunity to explain the proposed carve-out to HUSKY families and to more fully anticipate potential concerns with the implementation of the carve-out. Thank you for incorporating this addendum into our earlier comments.

Response: *The Departments agree with the recommendation. DSS and DCF will hold public meetings in several locations around the state during weekend and evening hours. Although the Departments have provided for family input through the Child Implementation Team, Children's Behavioral Health Advisory Committee, and, more recently, the Behavioral Health Advisory Committee, additional open forums for educating the public and soliciting input will be particularly important in this final period of planning and implementation.*

Sincerely,

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Connecticut Voices for Children

TRANSMITTED BY E-MAIL AND MAIL

April 5, 2005

David Parrella
Director, Medical Care Administration
State of Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

Re: Notice of Proposed Changes to the Connecticut Medicaid Managed Care 1915 (b) Waiver (HUSKY A)

Dear Mr. Parrella:

Connecticut Voices for Children would like to take the opportunity afforded by publication of the Notice of Proposed Changes to the Connecticut Medicaid Managed Care 1915 (b) Waiver (HUSKY A) in the Connecticut Law Journal on the March 1, 2005, to comment on our general concerns about the impact of this program change on access to care in the HUSKY Program.

This letter supplements the letter you already have received from Attorneys Victoria Velti and Greg Bass from Greater Hartford Legal Aid and Sheldon Toubman from New Haven Legal Assistance Association. Connecticut Voices concurs with the many concerns raised in that letter, and incorporates them herein by reference.

Statement of Interest. As you know, Connecticut Voices is a statewide, independent, non-profit organization dedicated to research and policy analysis on behalf of children, youth, and families in Connecticut. Because health care policy has an enormous impact on children's well being and family economic security, we are actively involved in collaborative efforts to ensure that families are well served by Connecticut's publicly-funded health care programs and associated health policy. In the past year and with the support of the Connecticut General Assembly, we resumed independent performance monitoring in HUSKY A, building on the work begun in 1995 when the Connecticut General Assembly established the Children's Health Council. This independent, "on the ground" monitoring (which complements own DSS' monitoring) has provided timely, policy-relevant information for policy development and program evaluation (including a full assessment of the effects of program changes and the use of state and federal dollars). Connecticut Voices' senior staff also have served on the Governor's Blue Ribbon Commission on Mental Health and Lieutenant Governor Sullivan's Cabinet on Mental Health, currently serve on the Federal Court Monitor's Advisory Panel, and participate in deliberations of the Medicaid Managed Care Council, and the Behavioral Health Oversight Council's workgroups. This work has all been directed at enhancing efforts to

identify problems and develop solutions that will improve access to behavioral health care services for children and families.

Position in short. Connecticut Voices supports the interagency collaboration that led to this proposal for carving out behavioral health care from a Medicaid managed care program. We share DSS' belief that this managed care model has been largely unable to bring about the system-wide change needed to improve access to behavioral health care services. We are concerned, however, that a change of this magnitude requires far better information, coordination, and evaluation than appears to be included in this proposed change. Because it is very at-risk children who stand to lose if these issues are not addressed in advance, we urge you to modify the proposal in a number of ways.

Coordination. We echo strongly the concerns you already have heard about the need to assure good care coordination between the MCOs and the ASO, as well as among clients, providers, and ASO and the MCOs. Just as DSS did when HUSKY was first introduced, this dramatic change should be accompanied by a well-coordinated, comprehensive, and *on-going* public education campaign to assure that all clients, providers, and staff at the MCOs and ASO understand the reform, how to access care, how to challenge denials or delays of care, etc. Allocating additional funds to case management – an EPSDT-required service (although not one that is routinely provided) – will be important, as will increased funding for Family Advocates and other parent advocacy/assistance initiatives. A much clearer articulation of how coordination of services is to be achieved is necessary *before* this change is implemented, as is public education about this reform.

Response: *The Departments acknowledge that the formal waiver amendment and cover letter only touch upon the many issues that need to addressed in detail before proceeding. Much though by no means all of the detail is contained in the KidCare ASO request for proposals, which is available at www.connecticutcommunitykidcare.state.ct.us. In addition, extensive planning has been done over the past year with the MCOs and within the Departments related to coordination. This planning is not yet complete and will certainly accelerate in the months preceding implementation—and it now involves members of the Behavioral Health Oversight Committee's Coordination of Care workgroup.*

Provider Education and Assistance

The Departments recognize the importance of working with providers, parents and consumers in the development of program policies. The Departments also recognize the importance of a well-coordinated, comprehensive, and on-going public education campaign to assure that all clients, providers, and staff at the MCOs and ASO understand the reform. The ASO has a range of responsibilities related to provider and recipient education and assistance in navigating the system. Toward this end, comprehensive training of ASO member services staff will be a requirement of the contract.

The ASO, under the direction of the Departments, will develop a provider handbook, and a semiannual newsletter as well as a web based inquiry site that will allow direct provider contact with the ASO and access to on-line information. At a minimum, the handbook will contain a mission and vision statement of KidCare, confidentiality provisions, procedures for accessing KidCare services, procedures for communicating with the Departments, summary of service and benefit structure, HUSKY MCO pharmacy program information, transportation procedures, procedures for submitting complaints and appeals, procedures for the authorization of services, summary of utilization management requirements, and a summary of claims procedures and MMIS vendor contact information.

The ASO will notify providers electronically of any changes in provider requirements that are not otherwise communicated by the Departments in policy transmittals. The ASO will also develop and implement an orientation program and technical assistance for providers prior to implementation including an initial statewide provider orientation initiative, and two orientation sessions for providers in five (5) different areas of the state during the first year. The ASO will provide targeted technical assistance for those providers who are identified as needing technical assistance. The ASO will also coordinate an annual review of utilization management policies and procedures with staff of the Departments and providers in order to improve those policies throughout the contract term.

Member Education and Assistance

The ASO will also do much to prepare members for the new system and to help them navigate the system. In addition to providing telephonic member services, the ASO will develop an informational recipient brochure written at a seventh grade reading level in both English and Spanish at least 60 days prior to implementation. The content of the brochure will explain KidCare benefits for recipients, describe how to access KidCare services, describe how to contact the ASO for assistance in navigating the KidCare system, and describe recipient rights and responsibilities, including grievances and appeals. The ASO will also develop a recipient handbook, that will describe the benefits available to recipients, the procedures for accessing services, rights and responsibilities, including Notice of Action, denial, appeal and grievance rights. In addition, the ASO will also provide through the Connecticut Community KidCare website information for recipients and their families concerning behavioral illnesses and the assistance available for recovery through KidCare. The website will allow for the exchange of KidCare information with providers and recipients, link to a provider referral search engine, and include the text of the Recipient handbook.

Finally, the ASO will assist the Departments in facilitating on-going semi-annual community meetings in each local area for the purposes of information sharing and feedback. Participants will include providers, parents, consumers, advocacy groups, members of Community Collaboratives, and representatives of the Departments.

Case management

With regard to case management, as noted earlier, access to case management will be markedly improved over current levels provided under the HUSKY program. There will be several types of case management as follows:

- *The ASO will provide intensive care management services. This is a special type of case management service that is targeted toward clients with complex behavioral health service needs and clients that are experiencing barriers to effective service. The quality and capacity of these ASO based case management services will be much increased beyond the level that currently exists in the HUSKY program. In addition, these Intensive Care Managers will be assigned to one or more DCF local areas and spend a significant amount of time in the field, working directly with providers and recipients as the need arises*

- *The ASO will also employ peer specialists who will work in conjunction with intensive care managers to help engage families and adult consumers in treatment.*

- *The fee schedule for clinics and independent practitioners will provide reimbursement for case management.*

- *The ASO will help link children with complex needs to DCF funded Care Coordination services. Care Coordination is a type of case management, similar to targeted case management, that specializes in wraparound individualized care planning.*

Financing. We are concerned that the $19.76 per member per month that is to removed from upcoming MCO capitation payments is inadequate to address the significant unmet need in the currently under-developed children's mental health system (even taking into account other funding sources and current system inefficiencies). Notwithstanding our fear that this share is too small, we are also concerned that the funds *remaining* with the Managed Care Organizations (MCOs) for mental-health related services (pharmacy, laboratory, emergency and non-emergency transportation, case management, etc.) as well as all other health services also will be too low to assure timely access to care. Because delay or denials of care by the MCO (and is subcontractors) for related services can – essentially –thwart access to medically-necessary mental health care, adequacy of this funding is essential. Periodic re-assessment of funding adequacy (with upward adjustments if necessary) is essential.

Response: *The Departments agree and have taken service growth into consideration in the KidCare waiver analysis and budget. As noted in our response to previous questions, the $19.76 pmpm is only one portion of the dollars that will be allocated to cover HUSKY behavioral health services under the carve-out. The $19.76 pmpm contained in the waiver amendment does not include the 7.76% growth in service expenditures that is anticipated as a result of moving these dollars out of a capitated managed care*

environment. Consistent with this analysis, the Governor's proposed budget provides for a 7-10% increase in service expenditures. These expenditures are part of the new $9.8 million that the Governor has proposed be available to support the initiative.

Oversight and evaluation. With great uncertainty about both the adequacy of coordination of services and also the adequacy of proposed financing, it is imperative that there be competent, independent and timely oversight of this reform initiative to assess whether the care required by federal Medicaid law is actually being provided to those who are eligible for it.

We are very concerned that the accountability and legislative oversight built into HUSKY A will not be carried over into the new program. Section A. III. G. 2 of the proposed waiver submission states:

Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. (emphasis added)

We believe that a program change of this magnitude warrants independent assessment of its impact on access and quality of care for many reasons, including:

- Connecticut mandates enrollment of children with special health care needs (including children in foster care and those receiving adoption assistance) who have the greatest needs for ongoing, intensive, developmentally-appropriate behavioral health services in the community and in acute care settings. Independent assessment is necessary to ensure that the quality of care for these very at-risk children improves through this change, rather than deteriorate.

- Medicaid managed care organizations will remain responsible for primary care, pharmacy coverage, laboratory services, and enabling services (assistance with appointment scheduling, non-emergency transportation). This creates the potential for major and minor disruptions when care coordination is not well-managed across agencies or administrative entities. Independent assessment will be able to assess if there is adequate care coordination (including by linking and then evaluating patient-specific data from the MCOs and the ASO).

- Contract compliance audits and administrative performance targets cannot replace in-depth, ongoing evaluation that shows just how the program actually serves children and families.

An evaluation of the impact of this program on children's mental health and health care should not be left to the two state agencies responsible for its execution or the contracted administrative service organization that administers the program. Appearances of a potential conflict of interest will always compromise the evaluation, no matter how

competent and complete it is. Neither, in the absence of federal requirements, should evaluation be largely nonexistent as it is in HUSKY B.

We believe that a policy change of this magnitude should always be data-driven and based on independently produced information with which to evaluate the success of the program and to identify future challenges for improving access to care. The effect of this carve-out on behavioral health care and on primary care and care coordination is no exception. It should be independently assessed, and the proposed changes to Connecticut's waiver should explicitly specify that this will occur. Further, independent performance monitoring should be ongoing, with special and timely attention to issues raised by the various stakeholders who are most affected by the program changes.

Response: *The Departments have received grant funding from the Center for Health Care Strategies to develop a national model for the ongoing assessment of the performance of the Connecticut Community KidCare reform. We are enthusiastic about this grant, which was awarded to Connecticut both because of the importance of this model of reform and the need to develop a comprehensive set of metrics for measuring the success of child mental health service systems. Notably, the Center for Health Care Strategies is among the nation's foremost experts in managed care reforms that affect children with special health care needs and their families. The development of this performance measurement system is predicated on stakeholder input into the selection of the measures, as recipients of periodic performance reports, and as advisors to the Departments in shaping future child mental health policy under KidCare.*

The Departments recognize that the performance measurement system is not an independent evaluation and that an independent evaluation will be necessary to answer the question as to whether the system meet's the Departments' goals in addressing the needs of children with special health care needs and adults with behavioral health disorders. The Centers for Medicare and Medicaid Services do not consider this reform to be a managed care reform and consequently would not ordinarily require such an evaluation as part of this waiver amendment. However, the Departments propose to include independent assessment of the ASO and the behavioral health carve-out in its External Quality Review Organization contract with Mercer and will indicate this in the letter to CMS.

Thank you for the opportunity of commenting on the proposed waiver amendment.
Sincerely,

Mary Alice Lee, PhD
Senior Policy Fellow

Shelley Geballe, JD, MPH

President

cc: Patricia Wilson-Coker, Commissioner
Mark Schaefer, PhD,
Senator Christopher Murphy, Co-Chair, Behavioral Health Oversight Committee
Jeffrey Walter, Co-Chair, Behavioral Health Oversight Committee